

# Children's

Speech and Language Services of Springfield, LLC

6354 Rolling Mill Place, #103  
Springfield, VA 22152

Phone:(703)866-0344  
Fax: (703)866-0233  
[www.cslstherapy.com](http://www.cslstherapy.com)

## CASE HISTORY FORM SPEECH, LANGUAGE AND HEARING DEVELOPMENT

Date \_\_\_\_\_

Child's Name \_\_\_\_\_  
Last First Middle Nickname

Birthdate \_\_\_\_\_

Parent's Names \_\_\_\_\_

Parent's Address \_\_\_\_\_  
Zip \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Work \_\_\_\_\_

Cell phone \_\_\_\_\_ e-mail \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Mother's Employer: \_\_\_\_\_

Father's Employer: \_\_\_\_\_

Your relationship to patient \_\_\_\_\_

Person who recommended our services to you \_\_\_\_\_

Name of Pediatrician \_\_\_\_\_

Primary reason for bringing your child for this evaluation: \_\_\_\_\_

I Birth and Developmental History Yes No

- A. Pregnancy
1. Was mother's condition during pregnancy good to excellent? \_\_\_\_\_
  2. Were medications taken during pregnancy? \_\_\_\_\_
  3. Were there any illnesses or complications during pregnancy? If yes, please give brief description. \_\_\_\_\_
  4. Was baby born at term (due date) or within two weeks before or after due date? \_\_\_\_\_
  5. What was birth weight? \_\_\_\_\_
  6. Was the child adopted? \_\_\_\_\_

- B. Labor and Delivery Yes No
1. Were labor and delivery normal? \_\_\_\_\_
  2. Was labor induced? \_\_\_\_\_



<u>Behavior</u>	<u>Age (from) Age (to)</u>	<u>Attempted to Alter these? (yes/no)</u>
Face Twitching _____		
Strong Fears/Nightmares _____		
Temper Tantrums _____		
Sleeplessness _____		
Nervousness _____		
Difficulty Sitting Still _____		
Inability to Stay with One Activity Until Completion _____		
Negative Behaviors _____		
Bedwetting _____		

Yes No

2. Does the child have the opportunity to play with other children his age? \_\_\_\_\_
3. If so, does he play with them? \_\_\_\_\_
4. Does he play with younger children? \_\_\_\_\_
5. Does he play with older children? \_\_\_\_\_
6. Are you ever concerned because he doesn't play well with other children? \_\_\_\_\_
7. What type of activity does your child prefer? \_\_\_\_\_
8. Primary type of discipline: spanking \_\_\_\_; isolation \_\_\_\_ (sending to room); verbal reasoning \_\_\_\_; other \_\_\_\_\_
9. Do you feel that your approach to discipline is effective? \_\_\_\_\_

**IV. Motor Development**

1. Please indicate age when the following skills were first performed:

<u>Skill</u>	<u>Age</u>	<u>Skill</u>	<u>Age</u>
Creeping _____		Holding Cup _____	
Crawling _____		Using Spoon _____	
Sitting Unassisted _____		Using Fork _____	
Walking _____		Using Crayons _____	
Hopping _____		Using Scissors _____	
Skipping _____			

Yes No ?

2. Has the child established handedness? \_\_\_\_\_  
If so, which hand? \_\_\_\_\_
3. Indicate age when voluntary bladder control was achieved? \_\_\_\_\_ Bowel control? \_\_\_\_\_

4. Was there any difficulty in toilet training? \_\_\_\_\_

V. Speech and Language Development and Behavior

1. At what age did he/she babble? \_\_\_\_\_  
Imitate words? \_\_\_\_\_  
Use his first word meaningfully? \_\_\_\_\_  
Put words together? \_\_\_\_\_

2. Did speech and language skills seem to develop normally and then stop or regress? \_\_\_\_\_

3. Does he understand what is said to him? \_\_\_\_\_

4. Does he follow spoken directions? \_\_\_\_\_

5. Does he talk in (check all that apply):  
single words \_\_\_\_; phrases \_\_\_\_; complete but grammatically incorrect sentences \_\_\_\_;  
complete, grammatically correct sentences \_\_\_\_;  
other \_\_\_\_\_.

6. Does he retell stories or experiences that can be understood? \_\_\_\_\_

7. Does he often hesitate and/or repeat sounds and words? \_\_\_\_\_

8. Is his speech: too fast \_\_\_\_; too slow \_\_\_\_; average \_\_\_\_?

9. Is his voice: too soft \_\_\_\_; too loud \_\_\_\_; average loudness \_\_\_\_;  
hoarse \_\_\_\_; nasal \_\_\_\_; denasal (stuffed as during a cold \_\_\_\_);  
other \_\_\_\_.

10. Has he ever had speech or language therapy:                      yes    no    \_\_\_\_\_

By whom? \_\_\_\_\_

Where? \_\_\_\_\_

Dates? \_\_\_\_\_

VI. Auditory / Sensory Behaviors

1. Does your child seem to have a hearing difficulty?                      yes    no

2. Is he inconsistent in his response to sounds and voices?                      yes    no

3. Is your child overly sensitive to noise? touch?                      yes    no

VII. Environmental History

**Names of Siblings**

**Birth Dates**

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**Others in the Home** \_\_\_\_\_  
\_\_\_\_\_

**Briefly describe daily environment. Does your child attend day care or have a primary care provider who has English as a second language? If so, what language is spoken?**

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**Have any other family member or relatives had the following difficulties?**

<u>Difficulty</u>	<u>Yes</u>	<u>No</u>	<u>Relationship to Child</u>
Speech or Language Problem	_____	_____	_____
Hearing Problem	_____	_____	_____
Learning Disability	_____	_____	_____
Reading Problem	_____	_____	_____
Emotional Problems	_____	_____	_____
Mental Problems	_____	_____	_____

**VIII. School History**

1. **Schools Attended** **Grade Level** **Dates** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. **Does his schoolwork seem inadequate in any areas?**                
**yes** **no**  
If so, in what areas? \_\_\_\_\_

3. **Please indicate present school hours**  
**Days of the week in attendance**

**IX. Other Evaluations**

**Has your child been seen by any other specialists?**                
**yes** **no**

**Who?** **Where? (Please list)**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_